Green Mountain Care Board
FY 2025 Budget Submission
OneCare Vermont Accountable Care Organization

September 27, 2024

144 State Street
Montpelier, Vermont 05602

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FY 2025 Budget Targets

The Board may add targets to guide the development or implementation of the ACO's Budget. Budget targets are not requirements for any budget submission. If the ACO's proposed budget varies from the budget targets below, the Board will review the ACO's proposed budget and its support for varying from these targets in its FY25 budget submission using the factors and criteria set out in statute and rule. For all budget targets that are met, the ACO should expect less analysis of this area of the budget from the GMCB and staff.

Budget targets set in the past have included an administrative expense ratio and a population health investment ratio, among others. Please see prior years' Budget Orders for examples.

Proposed budget targets for FY25:

1. The FY25 commercial benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings.
2. Maintain risk corridors for all public-payer programs at a minimum of FY23 levels or elect the new asymmetric risk corridor offered by Medicare. Downside risk for shared losses may be held centrally at the ACO level or dispersed to the network; this decision will be at the discretion of the ACO. If the ACO elects the asymmetric risk corridor, the ACO must maintain risk for the Medicare hospital AIPBP payment reconciliation at the ACO level consistent with the First Amended and Restated Vermont All-Payer Accountable Care Organization Model Agreement (2024 Amendment No.1). The ACO may propose a payment withhold or other mechanism consistent with the Medicare Participation Agreement.
3. With the exception of implementation of new waivers provided in the First Amended and Restated Vermont All-Payer ACO Model Agreement (2024 Amendment No. 1), the ACO's administrative budget should not support new programs in FY2025 in order to ensure final year expenses are appropriate to winding down the payment model. Administrative expenses should be targeted to those expenses associated with 1) programs demonstrated to yield positive benefits in terms of access, quality, and/or affordability for Vermonters and benefits for Vermont community providers, or 2) programs and resources necessary for it to support All-Payer Model requirements, or 3) meeting payer contractual obligations and/or participation requirements.
4. Ratio of operating expenses to PHM/payment reform payments (including FPP and budgeted bonus payments) must not exceed the FY24 revised budget amount.
5. The ratio of population health management funding to number of attributed lives must be at a minimum of the FY24 revised budget amount; specific line items may vary based upon any internal evaluation of the effectiveness of individual PHM programs.
6. Continue efforts around the three metrics that the ACO has selected to address in response to the March 2023 Medicare ACO Performance Benchmarking report through the Quality Evaluation and Improvement plan. The ACO should justify its choice of tactics to improve performance in these areas.
7. Should the ACO choose to participate as a Medicare Shared Savings Program ACO in FY25 and leave Vermont's All-Payer Accountable Care Organizational Model Agreement, OCV must submit a new budget that reflects the fact that its value to the state is more limited and must provide any and all additional information as requested by the Board.
8. Whether under the APM or MSSP, the ACO must account for its administrative budget by providing a breakout of the budget by function.

Section 1
ACO Budget Executive Summary

Section 1: ACO Budget Executive Summary

1. **Focusing on changes proposed for PY25, provide brief narratives to summarize the components of the budget submission and describe how the ACO's budget supports the efforts of the ACO, including:** ***(Max Word Count 1,500)***

   Performance year 2025 will be the final year of the Vermont All-Payer Model Agreement. With the potential for significant changes in 2026, the submitted budget reflects a "stay the course" approach to avoid multiple years of transition for participating providers. The primary goals of the 2025 budget are to:

   - Provide consistency to the participating providers through the final year of the All-Payer Model;
   - Comply with GMCB budget targets; and
   - Manage the cost of ACO infrastructure.

   The submitted budget achieves these goals by maintaining population health payment levels relative to 2024 on a per member per month (PMPM) basis, complying with all budget targets established in the 2025 budget guidance, and reducing operating expenses and hospital participation fees by 4.3% and 6.4%, respectively.

   OneCare recognizes the challenges Vermont, its health care system, and patients face regarding access, affordability, and sustainability. The submitted budget preserves benefits of the ACO model such as data sharing and financial accountability for health care costs in a manner that is mindful of the broader health care environment.

   a. **Summary of the Full Accountability Budget (Non-GAAP);**

      The Full Accountability Budget contains all components within OneCare's portfolio of programs, including funds that flow through the organization as well as funds that flow from payers directly to OneCare's network through risk arrangements. The 2025 budget contains similar components as in prior years (total cost of care, contract revenues, health spend, OneCare payment reform program spend and operating expenses, and provider payment expenses to be paid by payers). It is a balanced budget with no planned profit or loss.

   b. **Summary of the Entity-Level Budget (GAAP);**

      The Entity-Level (GAAP) Budget reporting seeks to demonstrate the full accountability items (income and expense) that remain in the budget in a traditional GAAP presentation. The major difference between the two representations is the Full Accountability budget reflects the full scope of OneCare programming including TCOC accountability, whereas the GAAP presentation excludes all pass-through funding for which OneCare is deemed to be acting in an agency capacity, e.g., TCOC/health care spend. Despite the pass-through nature of some funding streams, including these components in the Full Accountability Budget is important for transparency as OneCare

often directs the strategic apportionment and design of the programs and payment models.

c. **Summary of changes to ACO Network Programs, Population Health Programs, and Care Model; and**

Established in 2023, the Population Health Model (PHM) will continue in 2025 with most of the components and requirements staying the same. The care model and current quality metrics will remain, with targets for the measures adjusted to current benchmarks. The screening requirements that comprised the Mental Health Screening Initiative in 2023 and Mental Health Screening Incentive Program (MHSI) in 2024 will be added to the incentivized list of PHM quality metrics. The six network accountabilities (technology, care model, health equity, engagement, citizenship, and cost and quality performance), as well as Social Determinants/Drivers of Health (SDoH) also referred to as Health-Related Social Needs (HRSN) will be added to care coordination accountabilities in the PHM as prerequisites to qualifying for any incentives within the program. PHM payments will maintain the base plus bonus incentive structure for meeting targets, with further evolution of the ratio to continue to incentivize performance. The 2025 payments will be $4 PMPM base and $5.25 bonus, adjusting the ratio from 57:43 in 2024 to 43:57 in 2025.

In 2024, OneCare engaged nine Regional Clinical Representatives (RCRs), comprised of physicians, nurse practitioners, or physician assistants working in primary care, to provide support throughout the state. RCRs were identified through conversations with health service area (HSA) health care leaders and selected based on their local engagement in population health leadership. The RCRs are working closely with OneCare team members to review data and analytic reports specific to the primary care practices for which they are responsible for improving performance in PHM targets. In collaboration with OneCare, RCRs develop Performance Improvement Plans (PIPs) to focus communities on the targets that most need improvement. RCRs will be invited to continue their work in 2025 to support PHM progress and goal attainment.

As in 2023, OneCare continues to see improved performance on PHM targets in 2024, and we expect this progress will continue in 2025. Providers report that consistency in the measures year-to-year, alignment with programs outside of OneCare, and integration of program components reduce administrative burden and provides more opportunity for success, resulting in improved quality scores and higher incentive payments.

d. **Summary of lessons learned through programmatic evaluation. Response should include how these lessons will influence the ACO's programs in the budget year and beyond.**

OneCare uses quantitative and qualitative evaluation data to improve its population health programs and incorporates findings into budgeting and practice. In 2024, OneCare contracted with an external evaluation firm to independently evaluate its PHM. In addition, OneCare gathered ongoing feedback to inform program evolution through care coordination patient surveys, technology questionnaires, shared governance committees, and Comprehensive Payment Reform (CPR) practice reviews.

External quantitative PHM evaluation results will be delivered to OneCare in the late fall (delays due to external factors with payers have since been resolved). These results will be reviewed and any potential adjustments for PHM 2025 will be discussed through governance channels and with a careful eye toward impact on network participants given proximity to the implementation period.

Highlights from 2024 external evaluation qualitative findings include:

- Increased network engagement in PHM was achieved when OneCare blended previously separate population health incentive programs into one blended 2023 PHM;
- The primary driver of engagement was continuity across program and priorities. Respondents expressed appreciation for PHM alignment with other program requirements and priorities outside of OneCare (e.g. OneCare convening stakeholders to align on a tool for social determinants of health screening); and
- Additional interest expressed in how to access and use data to guide specific process improvement changes.

These findings influenced the decision to carry forward the 2024 PHM framework and measures into 2025; maintaining consistency and alignment with outside programs was shown to drive engagement. Also, in alignment with these findings, OneCare is continuing to refine the focus of its data engagement strategy to ensure appropriate tools are accessible and meaningful to participants. Provider feedback received through this process will inform system enhancements that optimize user experience and promote data driven process improvements in 2025.

Section 2
ACO Provider Contracts

Section 2: ACO Provider Contracts

1. **Describe any anticipated changes to the provider network for PY2025. Submit Appendix 2.1, 2025 ACO Organizations List and Appendix 2.2, 2025 ACO Provider Lists, provider contract, agreement, and any addenda as soon as they are final. Additionally, complete the following summary tables in the Excel Workbook. (*See* § 5.403 (a)8, (a)9) *(Max Word Count 250)***
    a. **2.2.1 Count of Individual Practitioners Contracted with the ACO**
    b. **2.2.2 Count of Entities by Contract Types**

    In 2025, there are two new organizations joining the network: one is an independent primary care practice in Addison County and the other is a naturopathic practice in Rutland County. There are six organizations departing the network in PY 2025; the organization types and reasons are detailed in the response to Section 2, question 2.

    See Appendices 2.1, 2.2, 2.2.1 and 2.2.2 in the enclosed ACO Budget Guidance Workbook. Also see Attachment A Network Agreements.

2. **Quantify the number and type of providers (i.e., primary care, specialty care, SNF…) that have left or who are likely to leave the network 2023-2025 (prior, current, and budget years) and to the best of your knowledge, their reasons for exiting. If applicable, explain any actions taken in response by the ACO to address the providers' concerns. (See § 5.403 (a)8; 18 V.S.A. § 9382 (b)(1)(D).)**

Table 1: ACO Provider Departures (2022-2025)

Departing provider type and count	PY of departure	Reason for departure	ACO Response (if any)
1 Primary Care	2023	Merged/Acquired or Closed	N/A
2 Primary Care	2024	Merged/Acquired or Closed	N/A
2 Specialist 1 SNF	2024	Did not return agreement	Multiple outreach attempts made.
1 Hospital	2025	Did not return agreement	After discussions over several months, the hospital decided to exit for 2025.
1 Designated Agency	2025	Did not return agreement	DA reallocated limited resources to becoming a certified community behavioral health center (CCBHC).
2 Specialists	2025	Did not return agreement	One exited due to lack of specific ACO programs/incentives for their organization type; One did not respond to multiple outreach attempts.
2 Physical Therapists	2025	Did not return agreement	No response to multiple outreach attempts.

Section 3
ACO Payer Contracts

Section 3: ACO Payer Contracts

1. **For any *new* payer contracts, complete Appendix 3.1, ACO Scale Target Initiatives and Program Alignment Forms for each sub-group that may exist within a payer contract. For all payer contracts, submit copies of each 2025 payer program contract, within ten (10) days of execution. (*See* § 5.403 (a)10.)**

   OneCare does not anticipate entering any new payer contracts for performance year 2025. Copies of OneCare's 2025 payer contracts will be submitted within ten (10) business days of execution, as required.

2. **Explain changes made to your portfolio of payer programs for the proposed budget year using the guidance below. For new and continuing payer programs discussion of anticipated changes should include changes to specific groups covered under payer contracts such QHP or self-insured groups within commercial contracts. (See § 5.403 (a)10.) *(Max Word Count: 1000)***
   a. **For any new payer program in 2025, describe the anticipated size and scope of the program and the impact on the budget model.**

      OneCare does not anticipate entering any new payer programs for performance year 2025.

   b. **For continuing payer programs that have Anticipated Changes, explain the anticipated changes and the overall impact on the budget.**

      The submitted budget anticipates 2025 payer programs/contracts continuing in generally similar form. However, there are some adjustments relative to 2024 terms.

      Medicare: Risk corridor reduced to the 3% level utilized in 2023. Note: OneCare is exploring the asymmetrical risk corridor option included in the 2025 Medicare contract amendment. This selection is required to be made later this calendar year, and if chosen would enable an increase in the savings potential. OneCare will keep the GMCB informed as more information about this option is known.

      Medicaid: The 2025 budget anticipates continuing with the Global Payment Program pilot. Payment estimates for those participating in 2024 were included in the budget, but there is potential for expansion. This initiative will be a topic discussed with the Department of Vermont Health Access (DVHA) during the program negotiation process. OneCare will keep the GMCB informed of any substantive changes or evolutions relative to the materials submitted.

      MVP: No substantive changes were incorporated into the 2025 budget.

UVMHN Self-Funded: In 2025, the [redacted]. OneCare will continue to make PHM program payments to those providers in a manner consistent with program design and policy, and [redacted] From a budgetary standpoint, this change results in a [redacted] and the PHM program expense, but does not alter the underlying spirit of the arrangement.

c. For any terminated payer programs, please explain the specific reasons for the change and any steps being taken to mitigate the impact of the terminated contract.

OneCare's payer program portfolio is anticipated to remain the same as in 2024; OneCare does not anticipate any payer program terminations for performance year 2025.

Section 4
Total Cost of Care

Section 4: Total Cost of Care

1. **Complete Appendix 4.1 TCOC Performance by Payer, Total ACO-Wide (2018-2025). (*See* § 5.403 (a)4, (a)10.) Instructions:**
    a. **Verify actuals for past years 2018-2022.**
    b. **Provide projections for the current and prior year (2023-2024) and the timeline for when actuals will be available.**
    c. **For the budget year (2025), provide expected TCOC.**

    See Appendix 4.1 in the enclosed ACO Budget Guidance Workbook.

2. **Complete Appendix 4.2, Projected and Budgeted Trend Rates by Payer Program and explain the following: (See § 5.402, § 5.403 (a)4, (a)10) (Max Word Count:500)**
    a. **All underlying assumptions for these trend rates (Appendix 4.2, Column D) including those related to changes in utilization, service mix, unit cost, etc., noting any significant deviations from the prior year. For programs subject to health insurance premium rate review by the GMCB, the 2025 benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings, if any.**

    The budgeted trend rates were determined using the best available information, but all remain estimates. For Medicare, the USPCC trend of 4.0%, less 0.2%, is used for both the total cost of care projection and the Advanced Shared Savings component. The Medicaid trend is determined by combining historic experience with emerging 2024 data. Commercial trends are informed by 2025 rate filings but will be more precisely determined though the contract negotiation processes.

    See Appendix 4.2 in the enclosed ACO Budget Guidance Workbook.

Section 5
ACO Network Programs and Risk Arrangement Policies

Section 5: ACO Network Programs and Risk Arrangement Policies

1. **Discuss ACO program goals, strategies, opportunities, and limitations for the following:** ***(Max Word Count: 1400)***
    a. **Strengthening primary care, including access and utilization; (See § 5.403 (a)13, (a)17; 18 V.S.A. § 9382 (b)(1)(A), (b)(1)(G))**

The ACO's goals and strategies for strengthening primary care in 2025 remain essentially unchanged from 2024.

Since OneCare's inception in 2012, strengthening primary care services has been both a core goal and a key value-based strategy. The two principal means for supporting primary care are the CPR program and the PHM.

Independent CPR practices have been strengthened by annual payment increases unmatched by any other primary care reimbursement program in Vermont. In 2024, CPR rates are as high as ten percent of the total cost of care, which, as a Primary Care Spend Rate (i.e., primary care spend divided by the total cost of care), is approaching the highest in the country. Since the majority of non-payer program funding is supplied by network hospitals, the program represents a meaningful transfer of financial resources to independent primary care organizations throughout the state in support of improved primary care service delivery.

Moreover, fixed payments to CPR participants allow providers to modify practice workflows to provide care without regard to fee-for-service revenue generation considerations, allowing them to focus on seeing individuals that need to be seen and performing non-billable activities in support of patient care. This efficiency in practice should improve overall access. Further, under the integrated mental health model, financial incentives are offered for universal screening for mental health disorders and for staffing mental health providers in the primary care office. This will continue in 2025.

From a quality incentive perspective, the PHM offers financial incentives for performance in metrics that are known to strengthen primary care, including annual wellness visits for both adults and children, chronic disease management, follow-up after ED visits for those with multiple chronic conditions, and integration of substance use and mental health services within primary care. To further improve engagement and partnership across the care continuum, OneCare's 2025 PHM will continue to include a quality measure focused on ensuring emergency department (ED) follow-up that will apply to all PHM-applicable provider types. The PHM offers primary care organizations a base PMPM to support quality improvement efforts and bonus payments to reward good outcomes. Limitations for OneCare are financial, as there are limited opportunities to redirect funds and limited staff to directly interface with primary care organizations.

As mentioned in the response to section 1, question 1c, in the second half of 2024 and continuing throughout 2025, OneCare engaged nine RCRs to improve progress on PHM measures, with primary focus on the ED follow-up measure. OneCare is budgeting for up to twelve RCRs for 2025, believing that data driven peer-to-peer support, education, and

encouragement can help primary care providers reach goals even more successfully. While the nine RCRs hired in 2024 cover most primary care practices, some are without this local provider support. Expanding the program in 2025 should allow for all primary care sites to benefit from local provider direction.

b. Reducing administrative burden of reporting requirements for providers; (See § 5.403 (a)17; 18 V.S.A. § 9382 (b)(1)(G))

OneCare has consistently met security standards to maintain limited remote access to over 30 electronic health records (EHR) across the network which helps alleviate the burden of data collection and performance reporting for annual quality measurement for each payer program.

Under the PHM, OneCare continues to evolve the ability for practices to perform self-reporting on Hypertension, Controlling High Blood Pressure, and Mental Health Screening rates. Using direct EHR reporting functionality, participants can report on their OneCare attribution or full population, relieving providers of any additional burden associated with custom or manual reporting. OneCare continues to provide support for the few practices still using paper records by performing reviews via manual intervention, allowing continued participation regardless of EHR status.

OneCare's continued participation in the Vermont Medicare ACO Initiative allows organizations with eligible clinicians the ability to receive an exemption from mandatory reporting under the Merit-Based Incentive Payment Systems (MIPS), highlighting the important benefit to those organizations in the OneCare Medicare program. Organizations have reported significant concerns about the additional burden when this exemption ends at the conclusion of the All-Payer Model.

c. Providing incentives for preventing and addressing the impacts of adverse childhood experiences and other traumas; (See § 5.403 (a)20; 18 V.S.A. § 9382 (b)(1)(J))

In 2024, through the implementation of the PHM, MHSI, CPR, and additional opportunities for Designated Agencies to earn incentive dollars, OneCare supports individuals with treatment needs relative to trauma. These programs will continue in 2025.

These initiatives are not exclusive to adverse childhood experiences (ACEs) and/or trauma; however, these incentive programs increase screening rates and funding, so providers can increasingly identify those with ACEs and/or trauma.

Developmental Understanding and Legal Collaboration for Everyone (DULCE) is a universal early intervention program uniquely designed to support families by providing screening for social determinants of health, legal support, parent coaching, and referrals to community-based resources. For the past four years, OneCare has partially funded four sites in the DULCE program with the understanding that funding would step down and transition to other sources over time. The timeline for this transition was extended

due to the pandemic, and 2024 serves as the final year of financial support. At the same time, in 2024 the legislature allocated funding for expansion and ongoing support of the DULCE program, allowing it to continue in 2025.

d. Expanding Fixed Prospective Payment arrangements; (See § 5.403 (a)17; 18 V.S.A. § 9382(b)(1)(G))

The 2025 budget includes continuation of the Medicaid Global Payment Program for the CPR practices and hospitals participating in the 2024 pilot. In partnership with DVHA, OneCare will explore expansion of this initiative to additional participants throughout the fall.

e. Monitoring and providing incentives for reducing potentially avoidable utilization; (See § 5.403 (a)13; 18 V.S.A. § 9382 (b)(1)(A))

OneCare's efforts to reduce potentially avoidable utilization have primarily been addressed by the 2024 PHM measures. Working with the network to improve wellness visits, ED follow-up workflows, and building trusted relationships between primary care and members demonstrates that establishing processes to appropriate care in the right place at the right time cultivates a systems approach to reduction of waste and over-utilization. Insights into utilization and gaps in care provide actionable information at the practice and HSA levels to facilitate next steps regarding trends in total cost of care, ED utilization, PCP visits, in-patient admissions and readmissions over time.

OneCare collaborates with and provides PHM incentives for Designated Agencies (DA), Area Agencies on Aging (AAA) and home health and hospice (HHH) agencies, reinforcing the shared care plan approach for individuals with multiple chronic conditions, mental health and substance use disorders to further reduce over-utilization and reinforce efficiencies and best practices for the ACO population.

f. Improving access to behavioral health services. (See § 5.403 (a)18-20; 18 V.S.A. § 9382 (b)(1)H-J), (b)(1)(P))

OneCare continues to support standardized mental health screening protocols to improve rates for both screening and follow-up for positive screening results. The MHSI is currently a voluntary program for organizations to provide screening results through a self-report option directly from their EMR using an online attestation process via OneCare's web-based platform. OneCare responded to primary care barriers related to capturing follow-up results through direct reporting by removing this as a requirement in 2024. However, the expectation to perform appropriate follow-up on positive screens remains. The number of primary care practices choosing to engage in this initiative has increased to 93% in June 2024, up from 80% in August of 2023.

Also new in 2024, practices must achieve a performance rate of 70% by December 31st to be eligible for payment. For eligible primary care locations not meeting target, OneCare requires a consultation with that organization to understand any limitation,

workflow issues, or other performance-related obstacles for them to qualify for the second incentive payment to be paid in February 2025.

In 2025, the 2024 MHSI activities outlined above will migrate into the requirements of the PHM, and no longer be voluntary. Care coordination, mental health screening, and SDoH/HRSN screening must all be performed and reported before PHM incentive bonuses become available.

Pediatric and adult wellness visits remain part of the current and ongoing PHM and annual quality measures. These preventive health visits provide an opportunity for screening and follow-up for mental health issues to be addressed promptly. Initiation and Engagement of Substance Use Disorder metrics were added to the PHM in 2024 to help incentivize a focus on this patient population. In addition to the opportunities for primary care, OneCare continues to extend performance-based incentives to DAs for appropriate follow-up after an inpatient stay or emergency department visit for mental health or substance use disorder treatment.

OneCare entered into an agreement with Brightside Health to pilot an arrangement to provide virtual mental health access for Medicaid-attributed members. This pilot is currently underway with CPR practices who have expressed a need for additional mental health support for patients. The pilot is anticipated to conclude at the end of 2024, and OneCare is partnering with DVHA to examine the benefits to their attributed members and determine next steps.

2. Complete Appendix 5.1, ACO Risk by Payer for the budget year. See Budget Target 2 in Part I – Budget Targets.

See Appendix 5.1 in the enclosed Budget Guidance Workbook.

a. If not already submitted to the Board, describe changes, if any, to the ACO's risk model and stratification methodology and rationale for these changes. (*See* § 5.403 (b)1-2) *(Max Word Count: 500)*

The risk model incorporated into the 2025 budget is consistent with the Risk Mitigation Plan presented and approved in June 2024. Exceptions from the standard approach include:

- Risk mitigation for Northeastern Vermont Regional Hospital (NVRH) that limits their Medicare savings and losses potential to 1%. This is offered to NVRH as they are the only unaffiliated Critical Access Hospital participating in the Medicare program.
- OneCare will cover the savings and losses for all attributing providers in the St. Albans HSA due the absence of a hospital risk bearing entity. This is a one-time strategy to sustain participation through the end of the All-Payer Model. OneCare reserves will be used to cover shared losses, if owed.

3. **If not already submitted to the Board, explain how the ACO would manage the financial liability for the risk included in the ACOs payer program agreements for the proposed budget year should the ACO's losses equal 100% of maximum downside exposure. In doing so, please discuss the following: (See § 5.403 (b)1-2) (Max Word Count: 500)**

   The approach included in the 2025 budget is consistent with the risk mitigation plan presented and approved in June 2024. In short, savings/losses are delegated to HSAs, with primary care receiving the first tranche through the Accountability Pool, and the hospital risk bearing entity receiving/owing the remainder.

   a. **In order to manage the maximum downside risk retained by the ACO or its founders, explain with what the risk is associated, how much, and how is this obligation funded (reserves, collateral, other liquid security, reinsurance, payer and provider withholds, commitment to pay at settlement, etc.)?**

      Any risk obligation owed by OneCare would be funded using reserves.

   b. **Does the ACO intend to purchase any third-party risk protection? If so:**
      i. **Explain the nature of the arrangement.**
      ii. **How does the anticipated protection compare to prior years?**
      iii. **How much of the downside risk would be covered?**
      iv. **Which programs would have this protection?**

      The 2025 budget does not include the purchase of any third-party risk protection.

   c. **If applicable, explain the nature and magnitude of any solvency or financial guarantee requirements imposed through payer contract arrangements and how the ACO aims to satisfy those requirements.**

      OneCare is required to provide Medicare with a financial guarantee for 1% of the total cost of care. OneCare will comply with this requirement using the line of credit option. The line of credit was increased to $15M so that the 2025 financial guarantee can be added even while the 2024 guarantee remains in place until program settlement.

   d. **Explain any other risk management strategies or arrangements that affect either aggregate ACO risk or individual provider risk.**

      OneCare has no other risk management strategies or arrangements to report beyond those previously discussed.

4. **Complete Appendix 5.2 Projected 2024 Accountability Pool Distribution and Network Settlement and provide any additional context as needed. (See § 5.403 (b)2) (Max Word Count: 250)**

   The projected 2024 settlement is expected to follow standard policy. The projections remain very early estimates and are subject to change as the year unfolds.

   See Appendix 5.2 in the enclosed ACO Budget Guidance Workbook.

Section 6
ACO Budget

Section 6: ACO Budget

1. **Complete Appendix 6.1 Income Statement, Appendix 6.2 Balance Sheet, Appendix 6.3 Cash Flow, Appendix 6.4 Staffing, Appendix 6.5 Variance Analysis, and Appendix 6.6 Sources and Uses (*See* § 5.403 (a)2-3)**

   See Appendices 6.1, 6.2, 6.3, 6.4, 6.5, and 6.6 in the enclosed ACO Budget Guidance Workbook.

2. **Revenues: Explain any line-item variations greater than 10% evident on your budgeted income statement as compared to prior year projected actuals and prior year revised budget. (*See* § 5.403 (a)2-3) (*Max Word Count: 500*)**

   Total revenues are increasing 12% over the 2024 Revised Budget and 2024 projection. The most notable revenue changes include:

   - Inclusion of the Global Payment Program (GPP) payments to participating hospitals ($107M).
   - Increase to the estimated Medicaid TCOC target ($32M).

   Other less substantive revenue changes exist that are often driven by attribution changes or programmatic adjustments. For a breakdown of all line-item variances over the identified threshold, see Appendix 6.5 Variance Analysis in the enclosed ACO Budget Guidance Workbook.

3. **Expenditures: Explain any line-item variations greater than 10% and $100,000 evident on your budgeted income statement as compared to prior year projected actuals and prior year revised budget. Please also explain: (*See* § 5.403 (a)2-3) (*Max Word Count: 600*)**

   Total expenses are increasing 12% over the 2024 Revised Budget and 2024 projection. This is due to the same factors affecting revenue as explained in Section 6, question 2.

   For a breakdown of all line-item variances over the identified threshold, see Appendix 6.5 Variance Analysis in the enclosed ACO Budget Guidance Workbook.

   a. **Any changes, including significant new investments to the ACO's infrastructure and the budgeted impact on expenses.**

      There are no significant new ACO infrastructure investments included in the submitted budget. Some infrastructure expenses deemed non-essential in the last year of the All-Payer Model have been removed or reduced.

      In spirit of further cost savings, the Medicare benchmarking expense and evaluation contract expense could be removed from the budget to reduce hospital participation fees by an additional $467k. However, because these expenses have been historically ordered by the GMCB they are included in the submitted budget. OneCare is happy to discuss the utility of these expenditures as the APM winds down with the GMCB and is willing to modify the budget accordingly.

4. **Balance Sheet: Explain any variations greater than 10% and $100,000 evident on your budgeted balance sheet as compared to prior year projected actuals and prior year budget and provide an analysis of the ACO's solvency, providing metrics that you use and noting any areas of concern. (*See* § 5.403 (a)2-3) *(Max Word Count: 250)***

Total assets and liabilities are expected to decrease by 29% and 55%, respectively, as compared to the 2024 Revised Budget. This is largely due to anticipated receipts and payouts of 2023 settlement dollars budgeted to be recorded as of 12/31/24 and paid in 2025. Since the budget does not assume shared savings or losses (beyond the Advanced Shared Savings for Blueprint/SASH payments), no corresponding receivables or payables are recorded at 12/31/25.

The comparison of assets and liabilities to the 2024 projected results is roughly the same as for the 2024 Revised Budget. In addition, a profit of $539,095 is expected in 2024 that results in a change in equity in the 2024 year-end balance sheet projection.

For a breakdown of all line-item variances over the identified threshold, see Appendix 6.5 Variance Analysis in the enclosed ACO Budget Guidance Workbook.

OneCare is committed to maintaining an appropriate level of equity, ensuring the amount is sufficient to maintain fiscal responsibility, yet small enough to prevent unnecessary costs passed on to hospitals funding the organization. OneCare has determined that the results of the ratios in Table 2 adequately demonstrate that the ACO is expected to remain solvent, therefore no areas of concern exist.

Table 2: Solvency

Ratio	OneCare Result	Standard
Debt Ratio	.36	Good < 1.0
Debt to Equity	.55	Good < 1; Risky > 2
Program EXP % of Total Exp	75%	Good: • American Institute of Philanthropy: 75% • Charity Navigator: 75%

5. **Cash Flow: Explain any variations greater than 10% and $100,000 evident on your budgeted cash flow statement as compared to prior year projected actuals and prior year budget and provide an analysis of the ACO's current cash position, as well as expectations for the upcoming budget year, noting any potential timing challenges. Please explain the use of, or access to, any revolving debt (including maximum allowable draw) or other debt used to mitigate cash flow challenges. (*See* § 5.403 (a)2-3) *(Max Word Count: 250)***

   The most notable item impacting the cash flow statement is $539k in net income projected for 2024, due to expense management. The 2024 Revised Budget and 2025 budget models are breakeven.

6. **Provide details of any expected capital expenditure over the next three years. (*See* § 5.403 (a)14) (*Max Word Count: 200*)**

   There are no planned capital expenditures over the next three years. This will be reevaluated as OneCare determines its post-All-Payer Model strategy.

7. **Complete Appendix 6.7, Hospital ACO Participation-All Hospitals for the proposed budget year. (*See* § 5.403 (a)2-3, (a)8)**

   See Appendix 6.7 in the enclosed ACO Budget Guidance Workbook. Of note, Northwestern Medical Center will not participate in 2025.

8. **Complete Appendix 6.8, ACO Leadership Compensation. (*See* § 5.403 (a)3; 18 V.S.A. § 9382 (b)(1)(M)) Additionally, please describe: (*Max Word Count: 250*)**

   See Appendix 6.8 in the enclosed ACO Budget Guidance Workbook.

   a. **Any changes to the factors considered when awarding variable pay since the last budget submission.**

      The variable pay model is expected to remain in similar form. The measures used to determine distributions change each year to align with OneCare's strategic priorities.

9. **Complete Appendix 6.9 Net Assets. Provide narrative context as necessary. (*See* § 5.403 (a)3)**

   See Appendix 6.9 in the enclosed ACO Budget Guidance Workbook.

10. Complete Appendix 6.10 Admin Budget by Function/Program. See Budget Target 7 in Part I – Budget Targets. Provide narrative context as necessary (*See* § 5.403 (a)3) *(Max Word Count 1,000)*

See Appendix 6.10 in the enclosed ACO Budget Guidance Workbook.

OneCare compiled this information in a manner consistent with the memo sent to the GMCB on July 23, 2024. Despite best efforts to supply the information requested, the division of staff time into each category is heavily reliant on estimates. Projecting how time will be spent in 2025, the last year of the All-Payer Model, is particularly difficult due to the possibility of strategic changes thereafter.

11. Complete Appendix 6.11 Population Health Management Expense Breakout. (See § 5.403 (a)2, (a)17-20; 18 V.S.A. § 9382 (b)(1)(G-J), (b)(1)(P))

- **a. Identify bonus payments where the ACO will budget the dollar amount, but not the actual distribution across provider types.**
- **b. Identify blank cells where provider types are ineligible for payments.**

See Appendix 6.11 in the enclosed ACO Budget Guidance Workbook.

12. Are there any actions, investigations, or findings involving the ACO or its agents or employees? If so, please provide any updates or additional information not previously provided to the GMCB. (*See* § 5.403 (a)6) *(Max Word Count: 500)*

There are none to report at the time of submission.

Section 7
ACO Quality, Population Health, and Model of Care

Section 7: ACO Quality, Population Health, and Model of Care

1. ***Model of Care*. Please briefly explain progress to date on implementing the Model of Care, including significant changes made during the current year. Include what changes will be anticipated for the proposed budget year, and describe any lessons learned and the rationale for the(se) change(s). (*See* § 5.403 (a)11, (a)16, (a)22; 18 V.S.A. § 9382 (b)(1)(F).) In doing so, please discuss the following: *(Max Word Count: 2,000)***

   Historically, OneCare's care model has centered on four populations of focus (High Emergency Department Utilizers; High Inpatient Utilizers; Individuals with High Total Cost of Care; and Individuals with High Medical Social Risk), in addition to the care management of high and very high-risk individuals as determined by historical health care utilization and clinical factors.

   OneCare has evolved from the use of these prospective risk and utilization factors as the basis for evaluation of care management intervention to using the Arcadia Impact Score (Impact Score), which allows health care organizations to identify patients most likely to benefit from the intervention of care management. The Impact Score combines multiple factors including emergency department utilization, cost, and unplanned admissions, and is integrated with social and economic factors influencing health.

   a. **Any elements of the care model or population health programs that OneCare has either eliminated or scaled up for FY25 including rationale for changes;**

      In 2025, OneCare will continue to scale up the use of the Impact Score for identification of individuals who could potentially benefit from a care management intervention. The goal of introducing the Impact Score is to increase efficiency within an organization that may experience capacity limitations and to help ensure individuals receive the right care at the right time. OneCare received feedback from the network indicating that continually increasing the volume of individuals served is challenging and yet it has responded positively to the Impact Score.

      With the reinvigoration of the RCR initiative in 2024, OneCare has scaled up network support and targeted quality improvement. Currently nine practicing providers who are physicians, nurse practitioners, or physician assistants are tasked with providing support to practices in their regions. The focus of the RCRs in 2024 is to develop performance improvement plans focusing on the PHM FMC (Follow-Up after Emergency Department Visits for Patients with Multiple Chronic Conditions) HEDIS measure. The rationale for this initiative is based on the need for increased performance improvement work and building on the connections that these clinicians already have with their local community. In 2025, OneCare anticipates expanding from nine to twelve RCRs to ensure all regions are fully covered.

b. All internal goals and strategies associated with the model of care for the proposed budget year and the strategies for their achievement;

The PHM continued to evolve in 2024 with the transition to quality metrics that align with approved measures where steward specifications, definitions, and applicable benchmarking are available for target setting. The selected metrics include domains aligned with annual quality measures, allowing opportunity to identify areas most in need of improvement. Timely education, quarterly reports, and HSA consultations assisted in fostering engagement with care coordination and quality results. These approaches and supports will continue in 2025.

In 2025, the PHM will continue to support the model of care and related goals of improving the coordination of care, care management, and quality improvement. The incentivized measures will not change, although targets will be updated based on the most recent benchmarks. An important change is that not only will care coordination be a requirement of the program, but mental health screening and SDoH/HRSN screening will also be required before participants can access incentive dollars.

In early 2024, with the endorsement of our Board and leadership, OneCare reinstated the engagement of RCRs. OneCare allotted funds to engage up to ten physicians, nurse practitioners, or physician assistants who are clinically practicing and who are also interested in supporting the PHM strategies and objectives at the local practice level. Thus far, OneCare has engaged nine RCRs who, partnered with a OneCare team member, have co-created and are driving work on practice-level Process Improvement Plans (PIPs). By partnering with these local clinicians, OneCare anticipates seeing greater movement towards our PHM goals. For 2024, RCRs are specifically focused on PIPs related to the HEDIS FMC measure.

OneCare plans to expand the RCR group in 2025 up to a maximum of twelve individuals, hoping to retain those already engaged at the current time. OneCare will continue to partner with the RCRs to drive improvements in PHM measures at the ground level in primary care and in collaboration with our continuum of care partners such as Visiting Nurse Associations (VNAs), AAAs, and DAs.

OneCare is working with Vermont Information Technology Leaders (VITL) to include Admission, Discharge and Transfer (ADT) data in the Arcadia platform by the end of 2024. The addition of this information will enhance data for network participants to drive quality improvement opportunities and meet PHM targets.

c. Any changes to how the ACO collaborates with the Blueprint for Health and continues to ensure non-redundant services and investments, that are in coordination with, and not in contradiction to, state objectives (e.g. All Payer Model, Department of Mental Health's Ten Year Plan, State Health Improvement Plan).

The responses provided in the 2024 budget narrative still stand for 2025, including:

- The care model aligns incentives across the continuum of care and is focused on PHM metrics;
- Unique ACO data is used to identify individuals who may benefit from care coordination efforts to close gaps in care and social needs;
- OneCare aligns strategies and shares progress regularly with DVHA, Blueprint for Health, commercial payers, the Agency of Human Resources, and other stakeholders as appropriate to avoid contradiction with the objectives of the state; and
- Leadership from ACO and Blueprint for Health communicate regularly and are committed to alignment in state population efforts and to avoid contradiction or redundancy.

From October 2023 through July 2024, OneCare, Blueprint for Health, and UVMHN Population Health Services Organization co-led in-person stakeholder working sessions aimed at achieving broad agreement in statewide processes for social determinants of health (SDoH/HRSN) screening and electronic data reporting of the responses to this screening. Stakeholders also identified a common desire for eventual governance of these data via the Health Information Exchange. Sessions were attended by 30+ leader representatives from government and commercial payers, all types of primary care providers/practices, continuum of care agencies, Agency of Human Services, VITL, VT RETAIN, and others. Together, stakeholders aligned on a common goal to conduct universal screening using the CMS HRSN screening tool.

Building on the success of these stakeholder convenings, a new series is planned to begin in fall 2024 to focus on controlling hypertension. This series will be hosted by OneCare and co-led by members of the Vermont Department of Health.

d. Any changes to how social determinant of health-related data is collected and how it is incorporated into the model of care;

OneCare has collaborated with statewide partners to propel efforts on a standardized format of screening for social health-related needs. OneCare has established the expectation of an electronic capture of a multi-domain screening at least annually and has facilitated multiple meetings to effectively support and endorse this transition. Primary care providers are incentivized by the PHM to incorporate these screenings into their workflows, and by 2025, achieve coding capacity to identify and capture health disparities and inequities that exist in their patient panels, and appropriately allocate resources to close gaps in care.

With the shift to the new Arcadia data platform in 2024, OneCare has gained insights into an Impact Score for each member, informed by data including socioeconomic status and patient demographics in addition to historical trends of utilization, disease state, health conditions, and morbidity. This helps shape the approach to patient panels that have the greatest potential for benefits of care management and considers metrics of health needs within the algorithm.

e. Any changes to how health equity is being addressed in the model of care;

OneCare has continued to address health disparities and the need to improve understanding of population health related needs in HSA consultations, quarterly practice level meetings, and webinars with statewide reach. Each of the 2024 and 2025 PHM measures require participants to evaluate the capture of health disparities and social determinants of health data, the intersection with quality improvement efforts, and their processes for engaging vulnerable populations. Screening for health-related social needs is required in the 2025 PHM program to access incentive funds.

OneCare formed a Health Equity and Access Workgroup to identify how best to address health disparities. The workgroup is exploring rates of annual wellness visits and referrals to specialists for vulnerable populations. The workgroup is facilitating conversations across the state to discuss access to care through library projects, technology/telemedicine expansion, standardization of health-related social needs screening, examination of provider perspectives, and oral health outreach programs to name a few. In addition, OneCare continues to enhance its care model through an equity-focused lens by:

- Providing data to inform care management potential through an Arcadia Impact Score that addresses the intersection of medical and social needs;
- Establishing a provider accountability that requires integration of SDoH screening tools and subsequent electronic data capture;
- Working with statewide stakeholders and network providers to establish workflows to capture SDoH/HRSN data within EHRs and transmit to the Health Information Exchange;
- Facilitating community best practices for positive HRSN screens with consideration of curated resources for providers to reference; and
- Ensuring ongoing improvement of data collection and screening for health disparities through shared governance and payer contracts.

f. Any waivers/benefit enhancements being offered in the proposed budget year.

OneCare has continued to offer to its participant network access to the CMS-approved Medicare Three-Day Skilled Nursing Facility (SNF) Benefit Enhancement Waiver in 2024. The SNF benefit enhancement waiver aims to improve quality and outcomes while lowering costs by reducing unnecessary hospitalizations or delays in accessing care. Without the waiver, individuals are required to have a three-day hospital stay before admission to a SNF. More than 300 ACO-attributed lives have benefitted from this waiver since the end of the public health emergency in May 2023, saving an estimated 1+ million dollars and lessening wait times for patients and families. OneCare plans to continue offering this waiver in 2025.

In 2024, OneCare is allocating $200,000 to support innovative care delivery ideas that utilize and benefit from ACO waivers. The first round of funding was awarded in late spring with waivers aimed at enhancing access to mental health care, reducing hospital readmissions, increasing preventive care measure performance, and improving overall health care accessibility for Vermonters. OneCare is currently assessing proposals for a second round of funding. In recognition of the strong positive response, OneCare has allocated $300,000 to fund similar waiver programs in 2025.

Additionally, OneCare is dedicated to supporting the implementation of all available ongoing or new beneficiary engagement telehealth waivers in 2025 and is working with home health and hospice agencies to pilot both the Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit and the Home Health Homebound waivers.

2. *Quality Improvement.* Report all results on Key Performance Indicator performance for FY23 and progress made to date using Appendix 7.1 KPI Performance. If any changes in measures, provider incentives, quality improvement framework or theory of change are being made for the budget year, please explain the changes and the reasoning behind the changes. (*See* § 5.403 (a)(11)) *(Max Word Count: 400)*

Based on regular feedback from OneCare's network, workgroups, subcommittees, and Board of Managers, OneCare identified a desire to align annual quality measures with established benchmarks. OneCare maintained the 2023 areas of focus (chronic disease management, preventive care, and emergency department utilization), and added a new focus area in the mental health substance use disorder domain. In 2025, the ratio of PHM base to bonus incentives will shift to add more weight on the bonus component. Also in 2025, SDoH and mental health screening will be required components within the PHM Program before incentive dollars will be paid.

See Appendix 7.1 in the enclosed ACO Budget Guidance Workbook.

3. ***Population Health and Payment Reform*. Complete Appendix 7.2, Population Health and Payment Reform Details. Please be sure to include, either within the workbook or as narrative below: (*See* § 5.403(a)(11), (a)(17-20); 18 V.S.A. § 9382 (b)(1)(G-J)) *(Max Word Count: 2,000)***

   See Appendix 7.2 in the enclosed ACO Budget Guidance Workbook.

   a. **information on the extent to which the ACO provides incentives for systemic health care investments to strengthen primary care, including strategies for recruiting additional primary care providers, providing resources to expand capacity in existing primary care practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care;**

      OneCare's PHM and CPR program both support incremental growth in access. CPR fixed payments and PHM base and bonus payments allow providers to modify practice workflows to provide care with less focus on fee-for-service revenue generation considerations, allowing them to focus on seeing individuals that need to be seen and performing non-billable activities in support of patient care. This efficiency in practice should improve overall access.

      Additionally, the integrated mental health model provides financial incentives for universal screening for mental health disorders and staffing mental health providers in CPR primary care practices. Incentives will be continued for 2025 and help support access to care in the primary care medical home.

      OneCare and its network are closely monitoring progress on quality measures, access to improved preventive care, management of chronic conditions, and follow-up after acute care encounters.

      While the ACO is not directly engaged in recruitment strategies for primary care providers, we believe that by providing reliable data and analysis of clinical areas of focus to drive necessary change and supporting practices in administrative efficiencies may indirectly influence retention of primary care providers in Vermont in a positive direction. OneCare's substantial funding of PHM incentive bonuses, CPR monthly payments, and incentives for mental health screening help stabilize and maintain primary care practice activities and staffing.

b. information on the extent to which the ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across the care continuum;

OneCare provides incentives to community-based providers (i.e. DAs, AAAs, HHHs) via the PHM to promote seamless coordination of care across the care continuum by improving in the FMC (follow-up within 7 days after an ED visit for those 18+ years of age with multiple chronic conditions) PHM measure.

Additionally, Designated Agencies can earn extra incentive dollars in three other follow-up measures including:

- 30 Day Follow-up after ED Visit for Substance Use
- 30 Day Follow-up after Emergency Department Visit for Mental Health Illness
- 7 Day Follow-up after Hospitalization for Mental Health Illness

Data in 2024 is trending in a positive direction for all these measures.

c. information on the extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers that are participating providers of an accountable care organization; and

OneCare is focused on promoting universal screening for health-related social needs and using the CMS Health Related Social Needs screener through aligned goal setting and education across organization types and stakeholder groups. This includes advancing electronic data capture of screening data and eventual aggregation of this information to support population health. Further, OneCare incentivizes systemic healthcare improvements through the implementation of the PHM program whereby participants are expected to complete clinically appropriate screenings and provide care coordination, referrals, and interventions for individuals with identified needs.

d. information on the extent to which the ACO provides incentives for preventing and addressing the impacts of adverse childhood experiences and other traumas, such as developing quality outcome measures for use by primary care providers working with children and families, developing partnerships between nurses and families, providing opportunities for home visits, and including parent-child centers and designated agencies as participating providers in the ACO.

The Developmental Understanding and Legal Collaboration for Everyone (DULCE) program continued to support families with adverse childhood experiences in 2024 with legal, parent coaching, mental health resources, and screening for ten different SDoH risk factors. Programmatic impact generated by a combination of early screening coupled with a strong relational focus, in addition to the increased availability of family specialists to be present on pediatric care teams early and often, has resulted in building trust in families and increased their willingness to be honest when providing information on their SDoH, enabling earlier identification and action on these elements in the care planning process. This program will continue in 2025 with centralized funding, as part of a broader sustainability plan.

Section 8
Performance Benchmarking

Section 8: Performance Benchmarking

1. **Complete Appendix 8.1 2023 and 2024 ACO Network Surveys. Provide an update to the 2023 survey that was in the field when the FY24 Budget was submitted. For each survey conducted, please describe the results, how the ACO responded to the results, and the outcome of the ACO's response(s). (Max Word Count: 500)**

Update on 2023 Care Coordination Survey (In the field when the FY24 Budget was submitted)
Survey Year: 2023
Population Measured: Individuals receiving care coordination services in each HSA.
Scope: Five question survey collected by field-based care coordination staff focused on individual experience with team-based care model.

Outcomes:

- 35% increase in response rate from 2023 (N=594) compared to 2022 (N=382).
- Table 3 demonstrates 2022 and 2023 percentages of respondents answering "always" to survey questions. There were modest declines in questions 1-3; a more significant change in question 4; and improvement noted in question 5.

Table 3: Care Coordination Survey – Percent Responding "Always" to Survey Questions

#	Survey Question	2022	2023
1	The people involved in my care communicated about my needs and goals.	72.25%	69.24%
2	The people involved in my care ask me what I think about things related to my health and support.	70.16%	68.55%
3	I am invited to meetings where my health and needs are talked about.	51.57%	49.24%
4	I have one person on my team identified as my primary contact (often referred to as Lead Care Coordinator).	92.93%	80.67%
5	I am treated like I am an important part of my own care team.	73.30%	76.13%

Responses to results:

- Sharing of results at network care coordination meetings to promote discussion, obtain feedback on barriers to engagement, and build on successes.
- Sharing of results with OneCare's Patient and Family Advisory Committee for discussion, input and suggestions regarding the survey design and their experience of the team-based care elements addressed in the survey.
- 2024 training focused on strategies for engaging individuals in care team meetings and delivering effective care team conferences.
- Promote network awareness of available OneCare care coordination training.

Outcomes of responses:

- Pending 2024 survey results.

Primary Care

Survey years: 2023, 2024
Populations Measured: Primary care participants of OneCare population health programs.
Scope: Mixed method evaluations of care coordination, Value Based Incentive Fund, and PHM incentive programs. Qualitative findings based on interviews with majority representation from primary care providers.

Outcomes:

- Programs collectively incentivize progression toward advanced primary care. (2023)
- Complexity in execution and incentives might have hindered participants' results. (2023)
- Qualitative results showed lack of clarity of OneCare's role in broader reform efforts, mixed feedback on utility of data and reports, and interest in receiving more process improvement support from OneCare. (2023)
- Blending multiple programs to form PHM in 2023 increased understanding of and engagement in PHM. (2024)
- The primary driver of engagement is continuity across program and priorities. Network expressed appreciation for alignment of PHM with other program requirements and priorities outside of OneCare. (2024)
- Additional interest expressed in how to access and use data to guide specific process improvement changes. (2024)

Responses to results:

- Alignment of previously separate incentive programs into one PHM program with streamlined expectations, areas of focus, and payments. (Response to 2023 results)
- Alignment of PHM quality metrics with other programs including Blueprint. (2023)
- Creation of data systems and reports in direct support of PHM. (2023)
- Establishment of Regional Clinical Representatives, local providers who work with their regions to embed workflows that improve PHM performance results. (2023)
- 2024 quantitative results will not be available until fall 2024 due to unanticipated payer data delays. Responses to 2024 results pending receipt of results.

Outcomes of responses:

- Improved understanding and engagement with PHM. (2023)
- Network appreciation for measure alignment across programs including those external to OneCare. (2023)
- Improved interest in access to and utilization of data to drive process improvement. (2023)
- OneCare will determine responses to 2024 quantitative and qualitative results following receipt of quantitative results.

Use of Technology: Arcadia

Survey years: 2023

Populations Measured: Primary care participants selected for the pilot phase of Arcadia based on high utilization of prior analytics system.

Scope: Nine question web survey released following fall 2023 pilot training sessions; focused on training effectiveness, system usefulness, and additional needs/suggestions.

Outcomes:

- 100% positive response in comprehension of training purpose and goals, understanding the baseline functionality of the system, and resources provided being easy to understand and follow.
- 85% of users felt prepared to use the system on their own after the initial training.
- Additional requests made for shorter, small group sessions within the live environment and creation of a Frequently Asked Questions (FAQ) reference.

Responses to results:

- Smaller, organization specific sessions hosted by OneCare covering expanded functionality and site-specific data within the live environment.
- Creation and distribution of a network FAQ embedded within recorded network training sessions, available for download to all new users.
- Training condensed from 90 to 60 minutes.

Outcomes of responses:

- Increased engagement and system proficiency has been observed by OneCare in response to conducting smaller, organization-specific sessions within the live environment.
- 98% of network users who completed online Arcadia training after receipt of pilot group feedback feel prepared to use the system on their own after initial training, a 13% increase over the pilot group.

Lastly, OneCare conducted a survey to understand the current characteristics of its Board of Managers and identify opportunities to improve its sense of inclusiveness. OneCare made a commitment to survey participants that results would not be shared outside of OneCare administration. In response to results, OneCare enhanced its Board's onboarding and recruitment practices by adding inclusive language in recruitment materials and broadening outreach to diverse communities for consumer positions.

See Appendix 8.1 in the enclosed ACO Budget Guidance Workbook.

2. Discuss any evaluation of the ACO's approach to conducting surveys, any improvements in surveying practices, and any plans for surveying stakeholders in FY25. ***(Max Word Count: 250)***

In early 2023, OneCare reviewed recent surveying activities with the Population Health Strategy Committee and Board of Managers. A theme emerged that prior survey efforts lacked centralized coordination, having been typically conducted by individual OneCare functional areas. To improve survey focus and quality, and support OneCare's ability to fully leverage all survey findings, in 2023 OneCare partnered with its evaluation contractor to design, implement and summarize priority program evaluation activities. This practice continued in 2024 with preliminary qualitative information suggesting that the consistency in approach has improved the ability to assess changes over time. Survey activities for 2025 are not yet determined.

3. Discuss the ACO's approach to evaluating its Population Health Management programs. Narrative must include, but is not limited to: ***(Max Word Count: 1000)***

OneCare's approach to evaluating its PHM programs is multifaceted. Clinical, financial, and utilization metrics are tracked to identify trends, outliers, progress towards goals, and opportunities for improvement. Network feedback in response to performance metrics and program execution is regularly solicited through OneCare's committee structure and biannual HSA consultation forums. Annual quality measure and financial results are evaluated to understand the broader collective impact of programs. Formal qualitative and quantitative program evaluation is conducted by OneCare's evaluation contractor. This multifaceted approach allows OneCare to design and implement programs in a data driven, agile manner.

a. Evaluation of the CPR program and the outcomes;

From a payment reform perspective, since the start of FY23, CPR practices have been reimbursed a percentage of the total cost of care, as opposed to a multiple of prior-year claims spend. Additionally, CPR practices were offered tiered payment rates between 8-9% TCOC for FY23, which was increased to between 9-10% for FY24-25. Overall, the CPR practices were reimbursed approximately 135% of fee-for-service in FY22, approximately 155% in FY23 (and are projected to be reimbursed approximately 155% in FY24). Although a payer-blended payment based on a targeted percentage of the TCOC presents challenges, the approach has been successful in that OneCare has materially increased reimbursement for these independent primary care practices

Within the PHM, CPR practices achieved 44% of measure targets as compared to 34% for the rest of the primary care network, per the most recent Q2 2024 reporting. By measure, CPR practices substantially outperformed non-CPR practices in four measures (Medicare annual wellness visits, hypertension control, child and adolescent wellness visits, and developmental screening).

b. The results of any evaluations completed on the PHM model to date and plans for further evaluation (include how TCOC, ED utilization, and inpatient admission rates have changed as a result of the revised care coordination model and whether or not these results are meeting expectations);

OneCare engaged an external entity to conduct evaluation activities in 2023 and has continued this arrangement in 2024. In 2023, OneCare launched the PHM to encourage improvement in quality and patient outcomes by offering financial incentives for meeting or exceeding performance targets for PHM measures and for meeting care coordination accountabilities. Thus far in 2024, OneCare has received initial qualitative findings and is awaiting final qualitative (including HSA focus groups) and quantitative findings. The initial qualitative findings focused on how the PHM influences primary care providers and their efforts to improve quality of care and patient outcomes. The following research questions were explored:

- How do practices experience the PHM?
- Where are practices prioritizing improvement efforts?
- Where are practices along the Health Care Payment Learning & Action Network (HCP LAN) accountable care curve?

Findings:

<u>How Practices Experience the PHM</u>:

- Increased understanding of and engagement in improvement efforts related to the PHM.
- Appreciation for improved program alignment.
- Funding is important, but not the primary driver of engagement.
- The primary driver of engagement is cohesion across programs and priorities.

Participants also provided suggestions for improvements to program design: consistency year-to-year in program requirements and metrics, and continued alignment across PHM, Blueprint, and PCMH.

Where practices are prioritizing improvement efforts:

- Preventive Care: Often involved adjustments to scheduling and documentation practices or revising workflows.
- Chronic Disease Management: Many testing workflow updates to ensure alignment with best practice recommendations. Increased patient and provider education programs.
- Utilization (Right Care, Right Time): Multiple practices have team members dedicated to completing follow-up phone calls after patients present at an emergency department or to ensure that patients with high blood pressure are seen again.
- Mental Health and Substance Use: Many different projects related to mental health and substance use; most indicated that this is a high area of need for their community.

Progress Along the Accountable Care Curve:
Variation in practice capabilities were observed along the HCP-LAN categories of health equity, quality, data and infrastructure, and multistakeholder alignment. OneCare was recognized for convening stakeholders to agree on a common SDoH screening tool. Many also commented on the value that OneCare provides in convening partners across the state including DAs and HHH agencies.

OneCare looks forward to sharing the quantitative results of the analysis when available later this year.

c. Process for monitoring and reporting the effectiveness of the Mental Health Screening and Follow-up Initiative;

The MHSI is currently a voluntary program for primary care organizations to self-report screening results directly from their EMR using an online attestation process via OneCare's web-based platform.

In 2024, two performance-based incentive payments will be distributed to qualifying program participants. Mid-year collection was performed to gather baseline screening rates to identify participants who achieved the payer-blended target rate of 70%. For eligible primary care locations not meeting target, OneCare is engaging with providers to understand any limitations, workflow issues, or other obstacles related to performance. These focused consultations provide an opportunity to address barriers in time for practices to qualify for the second incentive payment to be paid in February 2025.

The MHSI will be considered a success if there is an improvement in performance and overall growth of primary care participation. In 2024, 93% of primary care practices attested in this optional program, an increase from 80% in 2023.

d. How the ACO is incorporating provider and patient input on the model. Please share any relevant lessons learned.

OneCare regularly obtains provider and patient feedback through shared governance structures, workgroups, subcommittees, and committees. OneCare shares program evolution and policies with its Patient and Family Advisory Committee for discussion and input. Additionally, OneCare hosts HSA executive leadership sessions biannually to share data, information, and areas of opportunity. These sessions are also an opportunity for OneCare to gather provider input from all provider types across the state. For example, in the spring HSA executive leadership sessions, providers shared a desire for PHM measures to stay consistent moving into 2025. OneCare also contracted an evaluation of PHM, Value Based Incentive Fund, and care coordination which gathered provider input and feedback.

Medicare ACO Performance Benchmarking Report:

4. Please describe any changes to how OneCare is funding improvements in the metrics chosen for Budget Target 6 for FY25 (or note if this target was not met as prescribed). If these funding streams are unchanged from previous years, speak to how this funding has or has not made an impact on the ACO's performance in these areas. Have additional best-practices been gleaned from top-performing ACOs for the metrics in focus? *(Max Word Count: 300)*

OneCare's PHM aims to improve performance of metrics defined in Target 6: ED utilization, percentage of members with a primary care visit, and Medicare Annual Wellness Visits. Literature reviews, conversations with other successful ACOs, and learnings from those most successful in our network have all informed our selection of incentivized quality areas including the promotion of annual wellness visits and following up with complex patients after ED visits, both of which necessitate opening access to primary care and help reduce ED visits and re-visits.

The PHM funding and incentive model remains in similar form in 2025. OneCare is observing steady improvement in PHM measures and believes that by staying the course in this work we will continue to see meaningful change towards targets. Of note, the mix between PHM base and bonus payments will again shift to add more weight on the bonus component linked to outcomes, whereby driving engagement and ongoing change in a positive direction. In tandem, OneCare reporting is evolving to show practices their unearned bonus potential, if applicable, to increase the motivation to improve results. Additionally, the 2025 budget includes continuation of the RCR model restored in 2024. This approach is designed to generate deeper engagement and collaboration amongst participants.

Section 9
Other Vermont All-Payer ACO Model Questions

Section 9: Other Vermont All-Payer ACO Model Questions

1. **How are you ensuring that your portfolio of payer programs is aligned to support the goals (scale, cost, quality) of the Vermont All-Payer ACO Model?** ***(Max Word Count: 500)***

   For any contract OneCare negotiates on behalf of its provider network, OneCare considers the structure of the agreement and its potential benefit to providers and their patients. The greatest benefit of the All-Payer Model framework from a payer programs perspective has been the ability to align payers, programs, incentives, and quality metrics. This provided much needed focus and alignment for busy providers and their teams to engage in clinically meaningful ways to improve care delivery processes and outcomes across their patient panels. OneCare has worked to sustain our 2024 approach for 2025 and deliver payer contracts that meet the needs of providers and their patients and align under the All-Payer Model.